



COVID-19 Vaccine Patient Acknowledgment

Patient Name (Last, First):		DOB:/		
Phone: Mc		mail:		
(This information will be used to con-	tact you for your second dose reminder.)			
Address:	City, State, Zip Code:			
Sex listed at birth (check one):	on helps ensure we deliver equitable and pati	ent-centered care:		
Male: ☐ Female: ☐				
Gender identity (check one):				
	on-Binary Unspecified/Indeterminant:			
Fibrainity (Observations)				
Ethnicity (Check one):	n, Mexican, Puerto Rican, Cuban, etc. D Not-His	enonic A person not of Spanish gulture or origin		
Hispanic of Latino (including Spanish	i, Mexican, Puerto Rican, Cuban, etc.	spanic A person not of Spanish culture or origin $f L$		
Race: (Check all that apply):				
Black or African American	Asian	Hawaiian or Pacific Islander □		
White □	American Indian or Alaska Native	riawanan or r aomo iolandor 🗖		
Acknowledgements:				
for this vaccine. The fact sheet has the COVID-19 vaccine. I know the Food and Drug Administrate had the chance to ask questions the	information about side effects and adverse reactions. I ration (FDA) has authorized the emergency use of this at were answered to my satisfaction. I now know about			
	e area or an area told to me by my health care provider reactions If I have a history of certain allergic reaction	r after I receive my immunization so I am near my health (s), I must stay for 30 minutes. If I do not have a history		
	s I should call 9-1-1 or go to the nearest hospital. I know	face and/or throat, a fast heartbeat, a bad rash all over v I can call my health care provider if I have any side		
	gram. The program does health checks on the people w accine Adverse Event Reporting System (VAERS) at 1-	who get the COVID-19 vaccine. I know I should report 800-822-7967 or https://vaers.hhs.gov/reportevent.html.		
will become immune (not get the vir		time. I know that with all vaccines there is no promise I ose to not get the second dose of the vaccine. But if I do		
information to my primary care physician, authorities, for purposes of treatment, pa my health information as described in its Okanogan Douglas District Hospital (dba	Notice of Privacy Practices which I may receive upon r	I state or federal registries or other public health organization providing my vaccine will use and disclose request or find on its website. If I am an employee of cords of this vaccination for me in Evident / CPSI and may		
Patient (or Parent/Guardian/Authoriz	zed Representative) Signature:	Date:		
Name of Parent, Guardian, or Authorized Representative:		Date:		

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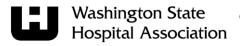
If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.

Please mail your completed form to Three Rivers Family Medicine, PO Box 577, Brewster WA 98812.

Once you submit your form, please allow at least five business days for our team to contact you for an appointment. Thank you for your patience!

All sections below are for official use only:

Vession Administration information for homeonics.	
Vaccine Administration Information for Immunizer:	
Administration date: Administration time:	
CVX (Product):	
Dose number:	
IIS Recipient ID:	
IIS vaccination event ID:	
Lot number:	-
Unit of Use MVX (Manufacturer):	_
Sending organization:	_
Vaccine administering provider suffix:	-
Vaccine administering site on the body: Left deltoid \Box Right deltoid \Box Other \Box (indicate the contraction)	cate location)
Vaccine expiration date:	
Vaccine route of administration:	-
Vaccination series complete (date):	=
Fact Sheet for Vaccine Recipients and Caregivers version date:	



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Pre-Vaccination Checklist for COVID-19 Vaccines



or va	ccine recipients:			
The follow any reason f you ans mean you questions	ring questions will help us determine if there is n you should not get the COVID-19 vaccine today. swer"yes" to any question, it does not necessarily u should not be vaccinated. It just means additional may be asked. If a question is not clear, please ask thoare provider to explain it.			
		Yes	No	Don't know
1.	Are you feeling sick today?			
2.	Have you ever received a dose of COVID-19 vaccine?			
	If yes, which vaccine product?			
	☐ Pfizer			
	☐ Moderna			
	☐ Another product			
	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
	Was the severe allergic reaction after receiving a COVID-19 vaccine?			
•	Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5.	Have you received another vaccine in the last 14 days?			
	Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8.	Do you have a bleeding disorder or are you taking a blood thinner?			
9.	Are you pregnant or breastfeeding?			

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Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

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